Imperial Cardiac Center
Imperial Valley Family Care Medical Group, APC

Patient Information Form

DOCTOR _____ **DATE** _____

PATIENT ACCT# _____

PATIENT INFORMATION **PLEASE PRINT**

LAST NAME	FIRST	MIDDLE		SEX ☐ M ☐ F
AGE	DATE OF BIRTH	STREET ADDRESS & MAILING ADDRESS (IF DIFFERENT)		APT. NO.
CITY	STATE	ZIP CODE	SOCIAL SECURITY NUMBER	
HOME PHONE	BUSINESS PHONE	MARITAL STATUS ☐ Single ☐ Married ☐ Separated		
PATIENT EMPLOYER / OCCUPATION		SPOUSE'S NAME		
PERSON TO NOTIFY (NAME & ADDRESS OF RELATIVE OR FRIEND NOT LIVING WITH YOU)			TELEPHONE NUMBER	
REFERRED BY	ADDRESS			

FINANCIAL RESPONSIBILITY

LAST NAME FIRST MIDDLE	SOCIAL SECURITY NUMBER	RELATIONSHIP TO PATIENT		
ADDRESS	CITY	STATE	ZIP CODE	
HOME PHONE	BUSINESS PHONE	EMPLOYER	ADDRESS	
VISA CARD #	EXPIRATION	MASTERCARD #	EXPIRATION	SIGNATURE

INSURANCE – PLEASE PRESENT INSURANCE CARD TO THE RECEPTIONIST WITH THIS FORM

NAME OF PRIMARY INSURANCE COMPANY		ADDRESS	
POLICY OR CERTIFICATE NUMBER	GROUP #	EFFECTIVE DATE	POLICYHOLDER'S NAME & DOB
NAME OF SECONDARY INSURANCE		ADDRESS	
POLICY OR CERTIFICATE NUMBER	GROUP #	EFFECTIVE DATE	POLICYHOLDER'S NAME & DOB

I CONSENT TO TREATMENT NECESSARY FOR THE CARE OF THE ABOVE NAMED PATIENT.

I AUTHORIZE THE RELEASE OF ALL MEDICAL RECORDS TO THE REFERRING AND FAMILY PHYSICIANS AND TO MY INSURANCE COMPANY, IF APPLICABLE.

I ACKNOWLEDGE FULL FINANCIAL RESPONSIBILITY FOR SERVICES RENDERED BY THE PHYSICIAN AND AUTHORIZE TRANSFER OF ALL UNPAID AMOUNTS TO MY VISA/MASTERCARD AFTER 120 DAYS FROM THE DATE OF SERVICE.

I UNDERSTAND THAT PAYMENT OF CHARGES INCURRED IS DUE AT THE TIME OF SERVICE UNLESS OTHER DEFINITE FINANCIAL ARRANGEMENTS HAVE BEEN MADE PRIOR TO TREATMENT.

I FURTHER AUTHORIZE AND REQUEST THAT INSURANCE PAYMENTS BE MADE DIRECTLY TO IMPERIAL VALLEY FAMILY CARE MEDICAL GROUP, APC.

_____

SIGNATURE **DATE**

Imperial Cardiac Center
Imperial Valley Family Care Medical Group

PERSONAL INFORMATION

YOUR NAME:		TODAY'S DATE:
BIRTHDATE:	BIRTHPLACE:	YOUR DOCTOR:
☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED ☐ LONG TERM RELATIONSHIP		
YOUR OCCUPATION:		FOR HOW LONG?

ILLNESS		PRIOR MEDICAL HISTORY		INJURIES	
ANEMIA	☐	CANCER	☐	HEAD INJURY	☐
HEART DISEASE	☐	PEPTIC ULCERS	☐	BROKEN BONES	☐
HIGH BLOOD PRESSURE	☐	SEXUALLY TRANSMITTED DISEASE	☐	BACK INJURY	☐
DIABETES	☐	PNEUMONIA	☐	**SURGERIES**	
TUBERCULOSIS	☐	HEPATITIS	☐	HERNIA	☐
STROKE	☐	KIDNEY DISEASE	☐	GALLBLADDER	☐
STOMACH ULCERS	☐	ASTHMA	☐	HYSTERECTOMY	☐
MEASLES	☐	BACK TROUBLE	☐	APPENDECTOMY	☐
MUMPS	☐	BLOOD TRANSFUSION	☐	PROSTATE	☐
ARTHRITIS	☐			OTHER:	
MIGRAINE HEADACHES	☐				

MEDICINES CURRENTLY TAKING	MEDICINES AND DRUGS		PERSONAL HABITS		
	ALLERGIES		SMOKING	☐ YES	☐ NO
	PENICILLIN	☐	ALCOHOL	☐ YES	☐ NO
	SULFA	☐	OTHER DRUG USE	☐ YES	☐ NO
	OTHER (PLEASE LIST)		USE SEAT BELTS	☐ YES	☐ NO
OVER THE COUNTER MEDICINES:					

FAMILY HISTORY

FATHER: ALIVE - HEALTH: MOTHER: ALIVE - HEALTH

DEAD - CAUSE: DEAD - CAUSE

BROTHERS / SISTERS:

HEART DISEASE	☐ YES	☐ NO	STROKE	☐ YES	☐ NO	HIGH BLOOD PRESSURE	☐ YES	☐ NO
ANEMIA	☐ YES	☐ NO	BOWEL CANCER	☐ YES	☐ NO	TUBERCULOSIS	☐ YES	☐ NO
BREAST CANCER	☐ YES	☐ NO	DIABETES	☐ YES	☐ NO			

JLJ: 04-94 DATA\FORMS\HLTH_HX.DOC

Patient History Questionnaire

(Please Also Complete Reverse Side)

SYSTEM REVIEW

CIRCLE YES OR NO IF YOU HAVE RECENTLY NOTICED:

GENERAL

SIGNIFICANT WEIGHT CHANGE	YES	NO
ABNORMAL BRUISING OR BLEEDING	YES	NO
FEVERS	YES	NO

HEAD AND NERVOUS

DEPRESSED MOOD	YES	NO
SLEEPING PROBLEMS	YES	NO
MEMORY DIFFICULTIES	YES	NO
HEADACHES	YES	NO
DIZZINESS OR FAINTING	YES	NO
EYE DISEASE OR INJURY	YES	NO
TROUBLE SEEING	YES	NO
WEAR CONTACT LENSES OR GLASSES	YES	NO
EAR OR HEARING PROBLEMS	YES	NO
RINGING IN EARS	YES	NO
NOSE BLEEDS	YES	NO
SORE GUMS	YES	NO

BREASTS

LUMPS	YES	NO
DISCHARGE	YES	NO

CARDIO-RESPIRATORY

SHORTNESS OF BREATH	YES	NO
SHORT OF BREATH LYING DOWN	YES	NO
ASTHMA OR WHEEZING	YES	NO
SIGNIFICANT COUGHING	YES	NO
COUGHING OR SPITTING UP BLOOD	YES	NO
CHEST PAINS	YES	NO
HEART PALPITATIONS	YES	NO

GASTROINTESTINAL

CHANGE IN APPETITE	YES	NO
DIFFICULTY SWALLOWING	YES	NO
HEARTBURN	YES	NO
EXCESS GAS	YES	NO
NAUSEA	YES	NO
VOMITING	YES	NO
VOMITING BLOOD	YES	NO
DIARRHEA	YES	NO
CONSTIPATION	YES	NO
HEMORRHOIDS	YES	NO
BLEEDING OR BLACK STOOLS	YES	NO

URINARY

URINE FREQUENCY	YES	NO
FREQUENT NIGHT URINATION	YES	NO
PAINFUL URINATION	YES	NO
BLOOD IN URINE	YES	NO
LOSS OF URINE CONTROL	YES	NO
SEXUALLY ACTIVE	YES	NO
SAFE SEX ACTIVITY	YES	NO

SKIN AND JOINTS

UNUSUAL PAIN IN JOINTS	YES	NO
SWELLING OR STIFFNESS	YES	NO
PAIN OR WEAKNESS IN MUSCLES	YES	NO
SKIN SORES OR RASH	YES	NO
LEG PAIN WHEN WALKING	YES	NO
MUSCLE CRAMPS	YES	NO

GYNECOLOGICAL

AGE WHEN PERIODS STARTED		
FIRST DAY OF LAST PERIOD		
USUAL LENGTH OF PERIODS		
USUAL PAIN WITH PERIODS	YES	NO
NUMBER OF PREGNANCIES		
NUMBER OF MISCARRIAGES / ABORTIONS		
NUMBER OF CHILDREN		

SIGNATURE / INITIALS OF MD REVIEWING:

IMPERIAL VALLEY
Family Care
Medical Group

PATIENT AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I, _____, understand **Imperial Valley Family Care Medical Group** is authorized by me to use or disclose my protected health information for a purpose other than treatment, payment, or health care operations. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information. I specifically authorize any current employee or owner of **Imperial Valley Family Care Medical Group**, or any other individual listed below to disclose my protected health information as described on this form to the recipients listed below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization, if done so according to the steps set forth below.

Description of the information to be used or disclosed *(check all that apply)*:

[ ] The patient's entire medical record
(NOTE: This requires an explanation why the entire record may be disclosed)

[ ] The patient's demographic information *(check all that apply)*:
[ ] Name [ ] Address [ ] State/Zip Code only [ ] Telephone
[ ] Age [ ] Gender [ ] Race
[ ] Other: _____

[ ] Medical Data/Information as related to:
[ ] Specific Condition(s): _____
[ ] Specific Professional Service(s): _____
[ ] Specific Medication(s): _____
[ ] Other: _____

[ ] Other: _____
_____

Name(s) or class of person(s) other than current employees or owner(s) authorized by this form to use and disclose the patient's protected health information:
_____

Name)s) or class of person(s) authorized by this form who may use and disclose the patient's protected health information:
_____
_____

Purpose(s) of the information:
_____
_____

[ ] *(Check if applicable)* This authorization is to be used for our own use, and **Imperial Valley Family Care Medical Group** will not condition treatment or payment on this authorization. Moreover, the patient has a right to inspect or copy the information to be used or disclosed and may refuse to sign this authorization.
[ ] *(Check if applicable)* The patient understands that **Imperial Valley Family Care Medical Group** may receive financial gain as a result of disclosing this information due to _____.
[ ] *(Check if applicable)* This authorization permits **Imperial Valley Family Care Medical Group** to send the protected health information ONLY to this address or fax number:
_____
_____
Any other address or fax number is not permitted by this authorization.

The patient has a right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization or, if applicable, during a contestability period. In order for the revocation of this authorization to be effective, **Imperial Valley Family Care Medical Group** must receive the revocation in writing. The revocation must include:

- The patient's name, address, and patient account number, if applicable,
- The effective date of this authorization, and the recipients of the protected health information according to this authorization,
- The patient's desire to revoke this authorization, and
- The date of the revocation, and the patient's signature.

Imperial Valley Family Care Medical Group will accept written revocations of this authorization via:
[ ] Certified U.S. Mail
[ ] Facsimile at this number:_____

ALL revocations must be sent to **Imperial Valley Family Care Medical Group** to the attention of the Privacy Officer, and are not effective until received by the Privacy Officer.

This authorization shall expire on _____. After this date, **Imperial Valley Family Care Medical Group** can no longer use or disclose the patient's protected health information without first obtaining a new authorization form.

I fully understand and accept the terms of this authorization.

_____ _____
Patient's Signature Date

FOR OFFICE USE ONLY
Authorization added to the patient's medical record on _____

Authorization verified by _____on_____

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